

**Kansas Department for Aging and Disability Services  
Workforce Enhancement in Nursing Facilities - Special Project  
Invoice-Summary**

Grant #: \_\_\_\_\_

Grantee Name: \_\_\_\_\_

Grant Period: From \_\_\_\_\_ to \_\_\_\_\_

Title of Course / Training Activity: \_\_\_\_\_

Billing period: From \_\_\_\_\_ to \_\_\_\_\_

Number of Individuals trained this invoice period:				
Unlicensed Staff	Licensed Staff	Total Staff	Unduplicated total # of facilities with employees attending training activity billed on this invoice	Total Amount Billed

ATTACH FORM KDOA 336a, Workforce Enhancement in Nursing Facilities - Special Project - Detail Invoice

I hereby certify:

1) The amount invoiced is for training of unlicensed staff currently employed by either a certified and licensed long-term care nursing facility (nursing home) or a long-term care unit of a hospital. No individuals employed in freestanding or attached Assisted Living Facilities, Residential Health Care Facilities, Home Plus Facilities, Boarding Homes, Home Health Agencies, Hospices, Hospitals and Hospital Swing Bed Units are included in this invoice.

2) To the best of my knowledge all training activities billed herein are in accordance with the Workforce Enhancement in Nursing Facilities, request for proposal, my agency's grant application and Notification of Grant award.

Authorized Official Name & Title: \_\_\_\_\_  
(Please type or print Name & Title)

Date Invoice  
Submitted: \_\_\_\_\_

Signature of Authorized Certifying Official: \_\_\_\_\_

Phone: \_\_\_\_\_

Contact Person: \_\_\_\_\_

**Kansas Department for Aging and Disability Services  
Workforce Enhancement in Nursing Facilities - Special Project  
Invoice-Detail**

Grant #: \_\_\_\_\_

Grantee: \_\_\_\_\_

Presented by: \_\_\_\_\_

Title of Course/Training Activity: \_\_\_\_\_

Date of Session: \_\_\_\_\_

Name/Locaion of Facility: \_\_\_\_\_

Name/Address of Presentation: \_\_\_\_\_

					CHECK ONE		No. of YEARS IN	
					Employed in:		current	employed
					Nursing Facility	Other	position	in LTC
Trainee/ Attendee	Position Title *(no abbreviations)	Certificate Number	License Number	Employer				
1								
2								
3								
4								
5								
6								
7								
8								
9								
10								
11								
12								
13								
14								
15								

\*May use Rn, LPN, CNA, CMA, SSD, AD. All other individuals needs to write out their position title.

**Kansas Department for Aging and Disability Services  
Workforce Enhancement in Nursing Facilities - Special Project  
Program Report**

**Grant #:** \_\_\_\_\_

**Grantee:** \_\_\_\_\_

**Title of Course/Training Activity:** \_\_\_\_\_

**Report Period:**       **From** \_\_\_\_\_ **To** \_\_\_\_\_

**PART I :     Number of Eligible Individuals Trained by Employer**

# of Individuals Trained	Employer
1 _____	_____
2 _____	_____
3 _____	_____
4 _____	_____
5 _____	_____
6 _____	_____
7 _____	_____
8 _____	_____
9 _____	_____
10 _____	_____
0	TOTAL NUMBER OF INDIVIDUALS TRAINED

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**PART II: Summary of Grantee progress in / toward implementation of grant activity.**

**PART III: Identify any Challenges encounter or lessons learned in connection with the implementation of this grant activity.**

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**PART IV:** Summarize Actions taken to overcome challenges encountered in implementation of grant activity.

**PART V:** Summary of recommendations.